



# EMPLOYEE'S CLAIM STATEMENT

State Form 45544 (R3 / 12-03)

STATE OF INDIANA  
State Personnel Department Benefits Division  
Disability Program

This form is confidential per IC 4-1-8 and  
31 IAC 3-1 4S.

Mail completed form to: JWF Specialty Co., Inc. (Third Party Administrator)  
PO Box 40968  
Indianapolis, IN 46240-0968  
Telephone: (317) 803-7200 or (317) 574-7876  
Fax: 317-574-7865

• The request for your Social Security number is MANDATORY  
according to IC 4-1-8 and this record cannot be processed without it.

EMPLOYEE'S CLAIM STATEMENT		
EMPLOYEE NOTE To avoid delay in processing be sure all answers are complete Use separate sheet if additional space is needed PLEASE PRINT.		
Name of employee		Social Security number *
Date of birth (month, day, year)	<input type="checkbox"/> Male <input type="checkbox"/> Female	Home telephone number
Address (number and street, city, state, ZIP code)		
Job title	Name of agency	
IF THE DISABILITY IS DUE TO AN ACCIDENT, PLEASE COMPLETE THE FOLLOWING SECTION		
Date and time the accident happened <input type="checkbox"/> A.M. <input type="checkbox"/> P.M.	Is it work related? (if Yes enclose Report of Injury ) <input type="checkbox"/> Yes <input type="checkbox"/> No	
Where did it happen? Give place / address. If at home, Indicate. ..... .....		
Describe injury and how it happened. ..... ..... .....		
If a vehicular accident, a police report must also be included.		
IF THE DISABILITY IS DUE TO AN ILLNESS, PLEASE COMPLETE THE FOLLOWING SECTION		
Nature of illness ..... .....		
Date it began:	Date last worked due to accident / illness:	Date first treated by a physician for this accident or illness:
Physician's name and address:		
Name / addresses of all other physicians treating this injury / illness:		
IF HOSPITALIZED DUE TO THIS ACCIDENT OR ILLNESS, ANSWER THE FOLLOWING		
Name of hospital	Date admitted (month day year)	
Address (number and street, city, state, ZIP code)		
I hereby certify that this is a true and complete statement to the best of my knowledge and belief. I understand that a fraudulent misstatement in completing this form will result in disqualification of eligibility for benefits.		
Signature of claimant **		Date signed (month, day, year)

\*\* If completed by other than the employee, please provide authorizing signature and relationship to the employee.